# Change Form

for group coverage

## Section 1 – Applicant Information (completion of this section is required)

First Name ____ MI ____ Gender ☐ Male ☐ Female ___/___/___ Date of Birth

Last Name ____ Suffix ____ ___-___-___ Social Security Number

Residential Address ____ (___) ___-___ Home Phone Number (___) ___-___ Cell Phone Number

City ____ Email Address ____

State ____ ZIP Code ____ +4 ____ County ____ Employed by ____

Mailing Address (if different from residential address) ____ (___) ___-___ Work Phone Number (___) ___-___ Fax Number

City ____ Group Number / Category ____

State ____ ZIP Code ____ +4 ____ County ____ Member ID Number ____

## Section 2 – Enrollment Information

I want to enroll in: ☐ Health ☐ Dental ☐ Vision

Reason for change:

☐ Open Enrollment ☐ Birth/Adoption ☐ Marriage ☐ Divorce

☐ Involuntary Loss of Coverage (explain) ____

☐ Other (give reason) ____

Official Date of Qualifying Event ___/___/___

**This is not the effective date.** Documentation of event may be required to complete enrollment. You will be notified if such documentation is required.

Do you have separate dental coverage with Blue Cross or another carrier? ☐ Yes ☐ No

## Section 2A – Adding Family Members to Coverage (please use extra sheet to add additional dependents)

Note: Complete all fields in section 2A for each dependent you wish to add.

Relationship to applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Legal Guardianship ☐ Legal Custody

First Name ____ MI ____ Gender ☐ Male ☐ Female ___/___/___ Date of Birth

Last Name ____ Suffix ____ ___-___-___ Social Security Number ___/___/___ Date of Marriage/Adoption

Type of health coverage for this dependent (check all that apply): ☐ Health ☐ Dental ☐ Vision

Do you have separate dental coverage with Blue Cross or another carrier? ☐ Yes ☐ No

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Relationship to applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Legal Guardianship ☐ Legal Custody

First Name ____ MI ____ Gender ☐ Male ☐ Female ___/___/___ Date of Birth

Last Name ____ Suffix ____ ___-___-___ Social Security Number ___/___/___ Date of Marriage/Adoption

Type of health coverage for this dependent (check all that apply): ☐ Health ☐ Dental ☐ Vision

Do you have separate dental coverage with Blue Cross or another carrier? ☐ Yes ☐ No

## Section 2A – Adding Family Members to Coverage (continued)

Relationship to applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Legal Guardianship ☐ Legal Custody

First Name ____ MI ____ Gender ☐ Male ☐ Female ____/____/____ Date of Birth

Last Name ____ Suffix ____ ____-____-____ Social Security Number ____/____/____ Date of Marriage/Adoption

Type of health coverage for this dependent (check all that apply): ☐ Health ☐ Dental ☐ Vision

Do you have separate dental coverage with Blue Cross or another carrier? ☐ Yes ☐ No

**Is anyone applying for this coverage enrolled in any other health/dental insurance (excluding Medicare, Medicaid or SRS)?** ☐ Yes ☐ No

Do you or any of your listed dependents have Medicare Parts A and/or B? ☐ Yes ☐ No

Are you entitled to Medicare due to ESRD (permanent kidney failure)? ☐ Yes ☐ No

Name of family member with Medicare coverage:

First Name ____ MI ____

Last Name ____ Suffix ____

Medicare ID Number ____

____/____/____ Part A Effective Date ____/____/____ Part B Effective Date

## Section 3 – Removing Family Members from Coverage (please use extra sheet to add additional dependents)

Check one: (please list specific members you are removing below)

☐ Change to employee only ☐ Change to employee and spouse ☐ Change to employee and child(ren)

☐ Retain family and terminate coverage for: ____

Reason for change:

☐ Divorce ☐ Child reaching age limit ☐ Death ☐ Other (give reason): ____

____/____/____ Official Date of Occurrence

Relationship to applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Legal Guardianship ☐ Legal Custody

First Name ____ MI ____ Gender ☐ Male ☐ Female ____/____/____ Date of Birth

Last Name ____ Suffix ____ ____-____-____ Social Security Number

Relationship to applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Legal Guardianship ☐ Legal Custody

First Name ____ MI ____ Gender ☐ Male ☐ Female ____/____/____ Date of Birth

Last Name ____ Suffix ____ ____-____-____ Social Security Number

## Section 4 – Other Changes and Comments

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I represent that all statements made herein are complete and true to the best of my knowledge. I understand that if I fail to provide any material information or if I intentionally misrepresent any material fact, such omission or intentional misrepresentation may result in the re-rating, termination or rescission of my health care coverage and/or criminal prosecution.

**To process the above changes, please sign and date:**

**Your signature required**

Applicant ____ ____/____/____ Date Signed

Plan Administrator Representative, Plan Sponsor Representative or Officer of the Company ____ ____/____/____ Date Signed